

Iowa Medicaid Enterprise

Incident Management Provider Access System

FORM 470-4698, CRITICAL INCIDENT REPORT, USERS GUIDE

Revised May, 2010

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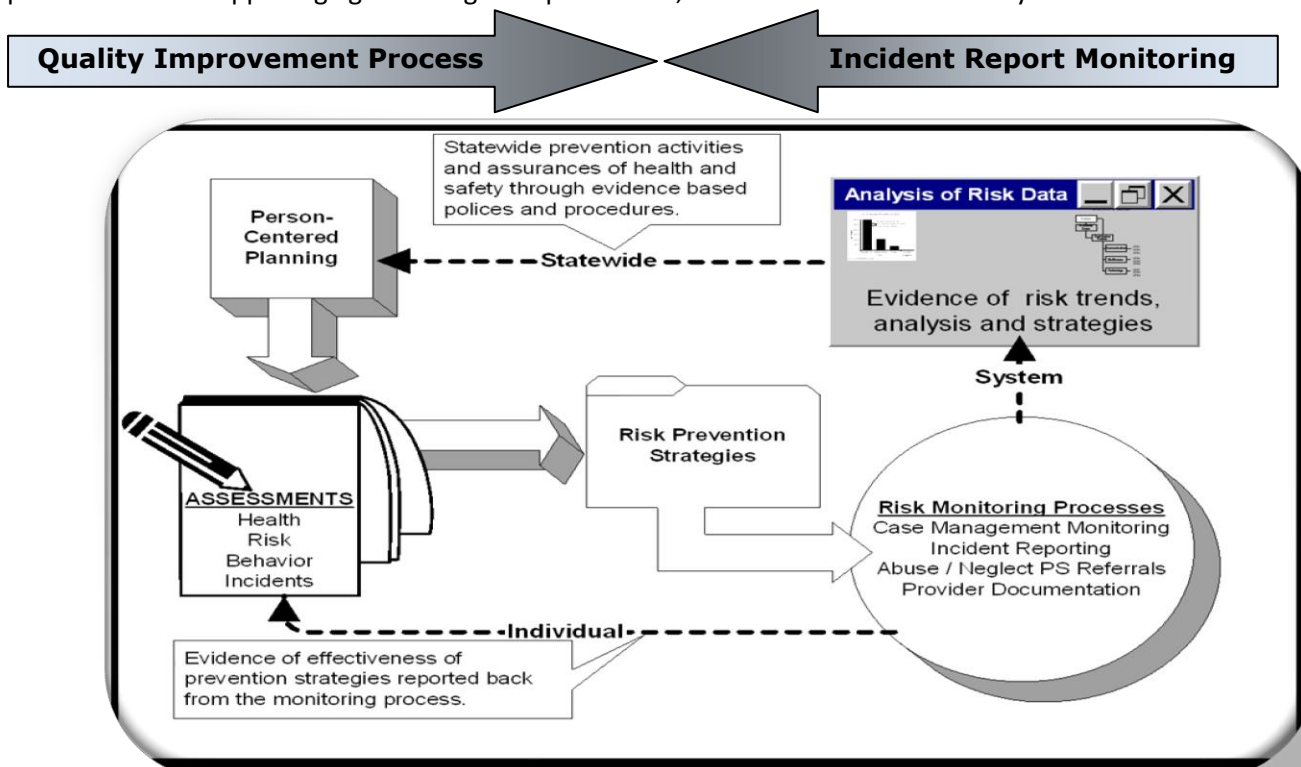
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INTRODUCTION TO IMPA

IMPA is the Iowa Department of Human Services' *Incident Management Provider Access* system. IMPA has been developed as a component of the Individualized Services Information System (ISIS). The Iowa Department of Inspections and Appeals, and other organizations, may have their own systems and requirements. This user's guide will provide you with all the information necessary to submit a major incident report to the Iowa Medicaid Enterprise (IME). The purpose of IMPA is to establish definitions, protocols, procedures and guidelines for the automated Incident Management System (IMS). The Incident Management System, for the purpose of this policy, means the consistent statewide process of identifying, classifying and reporting of major incidents, as well as conducting trend analysis reviews and reports of those incidents.

Accessing IMPA on the World Wide Web through Internet Explorer, Firefox, Opera, Safari or Google Chrome provides efficient and timely communications for all participants throughout the state. As you work with Medicaid waivers, habilitation, or case management services, you will be provided with appropriate permissions to access the IMPA system. This will allow you timely access to the most current information regarding all cases that involve you. For those without access to a personal computer, paper forms and instructions are available.

The IMPA system will provide structure and a consistent, statewide system of incident reporting, trend analysis, and risk management. This automation further refines existing policies and procedures that require incidents that bring harm, or have the potential to bring harm, to members, are immediately and routinely identified and reported upon to assure the member's health and safety. The end result will allow the implementation of measures that will prevent the recurrence of similar incidents, along with other activities that allow providers to be proactive in their responsibilities to reduce the risk of harm to members. By identifying the underlying environmental and system factors that have contributed to an adverse event, the system attempts to find out exactly WHAT happened, WHY it happened, and HOW it can be prevented from happening again. The goal is prevention, both at the individual and systems level.



INCIDENT REPORTING

These incident reporting standards apply only to providers who have direct contact with members. The standards define “major” and “minor” incidents, and set procedures and prescribe the content of incident reports.

MINOR INCIDENTS -- means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

Reporting Procedure for Minor Incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

MAJOR INCIDENTS -- means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in numbered paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned responsibility for oversight.

Reporting Procedure for Major Incidents

When a major incident occurs or a staff member becomes aware of a major incident:

1. The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:
 - a. The staff member’s supervisor.
 - b. The member or the member’s legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
 - c. The member’s case manager.
2. By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall report as much information as is known about the incident. The provider will report to the department’s bureau of long-term care either:
 - a. By direct data entry into the Iowa Medicaid Provider Access System, or
 - b. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
3. The following information shall be reported:
 - a. The name of the member involved.
 - b. The date and time the incident occurred.
 - c. A description of the incident.

d. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or non-members who were present must be maintained by the use of initials or other means.

e. The action that the provider staff took to manage the incident.

f. The resolution of or follow-up to the incident.

g. The date the report is made and the handwritten or electronic signature of the person making the report.

4. Submission of the initial report in IMPA will generate a workflow in ISIS for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

5. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

FORM 470-4698, CRITICAL INCIDENT REPORT

Once an incident has been identified as meeting the criteria for a Major Incident, assure that the health and safety of all individuals (member, staff and visitors) is addressed immediately.

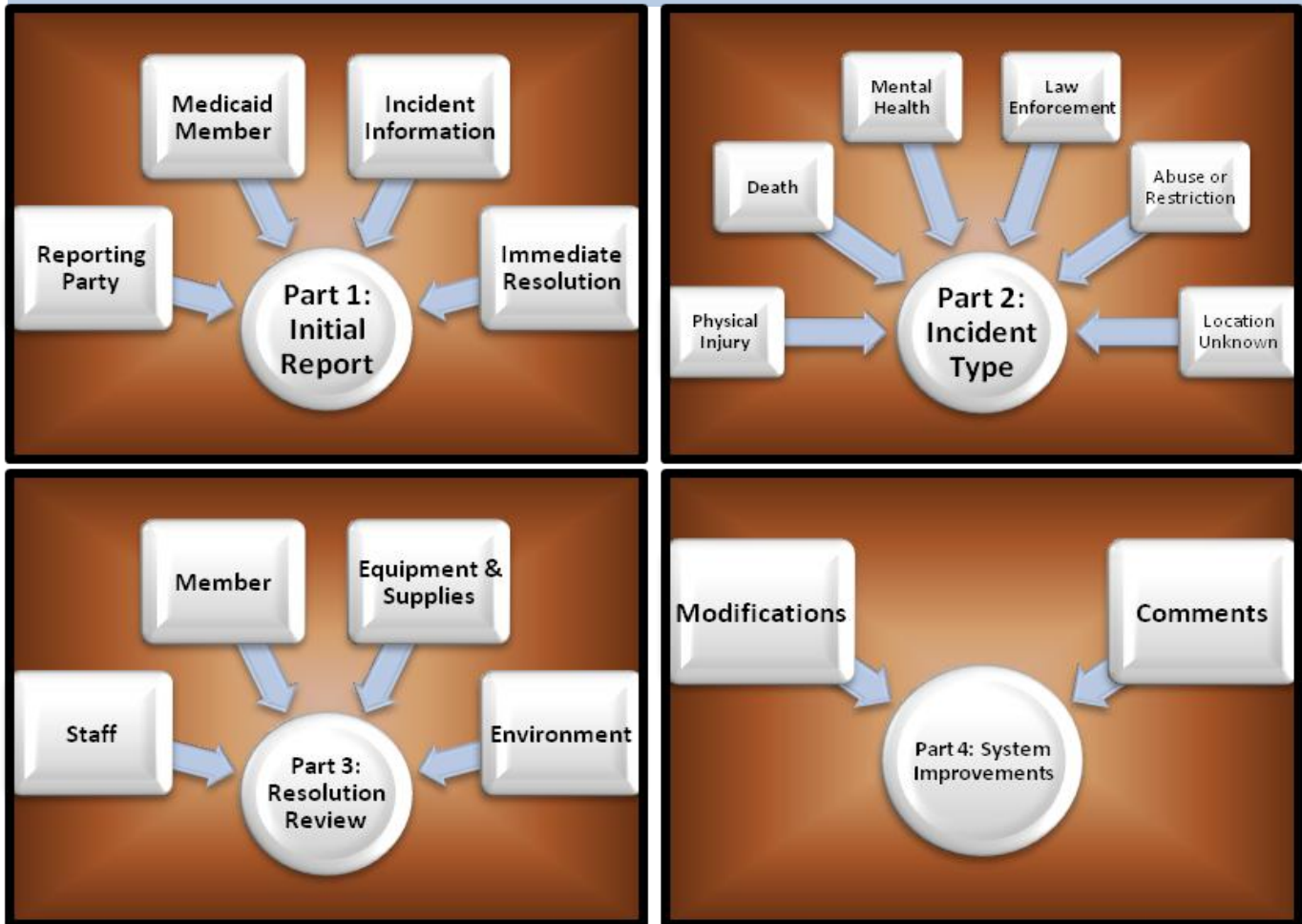
The Critical Incident Report, Form 470-4698 consists of four distinct parts. Part 1, Initial Report, must be completed and submitted by the end of the next calendar day following the incident.

Best practices recommend that an incident report be completed and submitted up to seven calendar days following an incident. If sections 2, 3 and 4 cannot be completed because necessary investigative activities are not yet complete and / or resolution activities have not been implemented, then the incident resolution should be updated and completed within 30 calendar days following the incident.

The Critical Incident Report, Form 470-4698 can be used to record multiple incident types if they relate to the same overall incident. If there are two distinctly separate incidents, two forms must be completed. The observer of the incident (or the staff involved) completes the Critical Incident Report, Form 470-4698 for any situation that meets the definition for a Major Incident. If the incident was not observed, the first person to become aware of the incident (or the first staff to become aware) completes the report. When there is more than one member involved in the incident, a report will be completed for each member. The report for each member will focus on the actions of that person and the steps taken by the provider on behalf of that person.

This guide will provide detailed information on each part and the sections within each part. Screenshots of the Critical Incident Report, Form 470-4698 have been provided as well as a graphic representation for ease of navigation.

Figure 1: Critical Incident Report Form 470-4698



PART 1 – INITIAL REPORT

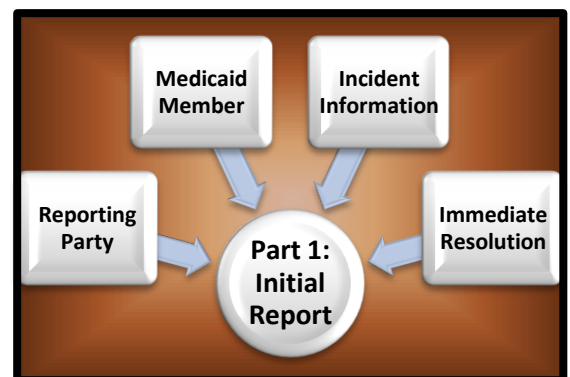
Part 1 must be completed and submitted by the end of the calendar day following the incident. Part 1 consists of four sections. Information is completed on the:

REPORTING PARTY: - The Medicaid provider (including case management entities) who witnesses, or first becomes aware of the incident.

MEDICAID MEMBER: - The waiver or habilitation recipient of services who was involved in the incident.

INCIDENT INFORMATION: - Information on the location, conditions, and involved individuals, as well as a short narrative, on the circumstances surrounding the incident.

IMMEDIATE RESOLUTION: Information on the assurance of health and safety for all individuals involved.



The **REPORTING PARTY** is the Medicaid provider (including case management entities) who witnesses, or first becomes aware of the incident. Fields in the reporting party section of the Initial Report include:

- **NATIONAL PROVIDER IDENTIFIER (NPI):** - The vendor identification number also referred to as the NPI (National provider identifier) for agency providers. For individual providers, the SSN (social security number) of the provider serves as the vendor identification number.
- **PROVIDER (NAME OR AGENCY):** - A person or business that provides medical services to a Medicaid member. The name of the agency or individual associated with the NPI or SSN should be entered.
- **PROVIDER ADDRESS, CITY, STATE, AND ZIP:** - The provider's main address (address, city, state, zip) should be entered.
- **COUNTY:** County where provider's main work center is located. In the case of an individual provider, the county would be the county in which they reside.
- **PHONE #:** - The provider's phone number.
- **FAX #:** - The provider's phone number for receiving FAX transmissions.
- **REPORTER NAME (LAST, FIRST, MI):** - The person completing the form. (Please note: If the incident report involves a child or dependent adult abuse referral, the reporter's name, title and email address will not be entered into the IMPA system.)
- **REPORTER'S TITLE:** - The title of the job position for which the person is employed. For an individual provider, the job which they perform. For example, an individual CDAC provider would enter "CDAC provider".
- **REPORTER'S EMAIL:** - The email address of the reporter.

Figure 2: Medicaid Member, Part 1, Initial Report

| | | | |
|------------------------|--|--|--|
| Medicaid Member | Medicaid No: _____ | Name: (Last) _____ (First) _____ (MI) _____ | HCBS Waiver: <input type="checkbox"/> Aids/HIV |
| | Address _____ City _____ | | <input type="checkbox"/> Ill & Handicapped <input type="checkbox"/> Brain Injury |
| | State _____ Zip _____ | County _____ | <input type="checkbox"/> Physical Disability <input type="checkbox"/> Elderly |
| | Date of Birth: _____ | Member's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Children's Mental Health |
| | Case Manager Name: (Last) _____ (First) _____ | | <input type="checkbox"/> Intellectually Disabled (formerly MR) |
| | (Email) _____ | | State Plan: <input type="checkbox"/> Habilitation Grants: <input type="checkbox"/> MFP |

The **MEDICAID MEMBER** is the waiver or habilitation recipient of services who was involved in the incident. Fields in the Medicaid member section of the Initial Report include:

- **MEDICAID NO:** - Identification number assigned to the member consists of seven digits followed by a letter. Also known as the State Identifier (SID) on ISIS screens.
- **MEMBER NAME (LAST, FIRST, MI):** - The member's legal name as associated with the Medicaid number.
- **MEMBER'S ADDRESS (ADDRESS, CITY, STATE, ZIP):** - The address of the member's primary resident. This must be a physical address, not a post office box.
- **COUNTY:** The county where the member lives.
- **DATE OF BIRTH:** - The member's birthday in mm/dd/yyyy format, where mm=month, dd=day, and yyyy=year.
- **MEMBER'S GENDER:** - Select the correct gender for the member.
- **CASE MANAGER'S NAME (LAST, FIRST):** - The name of the targeted case manager (TCM), HCBS case manager (HCBS-CM) or IDHS social worker (SW) assigned to provide oversight and monitoring of the member's plan of care.
- **CASE MANAGER'S EMAIL:** - The email address of the TCM, HCBS-CM or SW.
- **HCBS WAIVER:** - Select the Home and Community Based Services Waiver in which the member is enrolled.
- **HCBS WAIVER ILL & HANDICAPPED:** - The IH waiver provides services for persons who are blind or disabled. An applicant must be less than 65 years of age.
- **HCBS WAIVER AIDS/HIV:** - The AIDS/HIV waiver provides services for persons who have an AIDS or HIV diagnosis.
- **HCBS WAIVER INTELLECTUALLY DISABLED (formerly MR):** - The ID (MR) waiver provides services for persons with a diagnosis of mental retardation.
- **HCBS WAIVER BRAIN INJURY:** - The BI waiver provides services for persons who have a brain injury diagnosis due to an accident or illness. An applicant must be at least one month of age but less than 65 years of age.
- **HCBS WAIVER PHYSICAL DISABILITY:** - The PD waiver provides services for persons with a physical disability. An applicant must be at least 18 years of age, but less than 65 years of age.
- **HCBS WAIVER ELDERLY:** - People who are at least 65 years old may qualify for the elderly waiver program if they need an intermediate or skilled nursing level of care.

- **HCBS WAIVER CHILDREN'S MENTAL HEALTH:** - The CMH waiver provides services for children who have been diagnosed with a serious emotional disturbance.
- **STATE PLAN HABILITATION:** - Habilitation Services are designed to assist participants with chronic mental illness in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.
- **GRANTS MFP:** - The Money Follows the Person grant is utilized to expand services beyond what is currently offered under the Intellectually Disabled and Brain Injury waivers to provide services to individuals transitioning into the community from ICF/MR's.

Figure 3: Incident Information, Part 1 Initial Report

| | | |
|---|---|---|
| Incident Information | Date of Incident: _____ Time of Incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unknown | |
| | The Incident Was: <input type="checkbox"/> discovered <input type="checkbox"/> witnessed | |
| | First staff person to learn of the incident: (Name) _____ (Title) _____ | |
| | Location where incident occurred: (select one) | |
| | <input type="checkbox"/> Member's Home <input type="checkbox"/> private residence/household – living alone <input type="checkbox"/> private residence/household – living with relatives <input type="checkbox"/> private residence/household – living with unrelated persons <input type="checkbox"/> community supervised living <input type="checkbox"/> RCF <input type="checkbox"/> RCF/MR <input type="checkbox"/> RCF/PMI <input type="checkbox"/> assisted living <input type="checkbox"/> other _____ | <input type="checkbox"/> Community <input type="checkbox"/> community job <input type="checkbox"/> school <input type="checkbox"/> day program <input type="checkbox"/> work activity <input type="checkbox"/> homeless/shelter/street <input type="checkbox"/> vehicle <input type="checkbox"/> shopping <input type="checkbox"/> dining <input type="checkbox"/> recreating <input type="checkbox"/> other _____ |
| Other People Present (Provide name of person, initials if a member, and their relationship to the member) 1. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 2. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 3. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ 4. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____ | | |
| Services: (select one) <input type="checkbox"/> Services were not being provided. <input type="checkbox"/> Service being provided at the time of the incident: W code _____ Service Name _____ | | |
| Describe the incident, including Who, What, When, Where, and How. (Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Include what was observed or heard. Attach additional pages if needed) | | |

The **INCIDENT INFORMATION** section of the Initial Report collects information on the location, conditions, and involved individuals, as well as a short narrative, on the circumstances surrounding the incident.

Figure 4: *Date & Time of Incident*, Part 1 Initial Report

| | |
|--|--|
| Date of Incident: _____ Time of Incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unknown | |
| The Incident Was: <input type="checkbox"/> discovered <input type="checkbox"/> witnessed | |
| First staff person to learn of the incident: (Name) _____ (Title) _____ | |

Fields in the **Incident Information** section of the Initial Report include information on the date and time of the incident:

- **DATE AND TIME OF INCIDENT:** - Enter the date and time that the incident was observed or discovered. Select either AM or PM.
- **DISCOVERED:** - Select this checkbox if the staff person discovers, or is told, of an incident but was not present, was not involved, or where the incident is suspected.

- **WITNESSED:** - Select this checkbox if the staff person observed or was involved in the incident.
- **FIRST STAFF PERSON TO LEARN OF THE INCIDENT:** - This person should be the witness or the discoverer of the incident (or the staff involved).
- **STAFF TITLE:** - The title of the job position for which the person is employed. For an individual provider, the job which they perform. For example, an individual CDAC provider would enter “CDAC provider”.

Figure 5: Location of Incident, Part 1 Initial Report

| Location where incident occurred: (select one) | | |
|--|--|---|
| <input type="checkbox"/> Member's Home | <input type="checkbox"/> Community | <input type="checkbox"/> Other Location |
| <input type="checkbox"/> private residence/household – living alone | <input type="checkbox"/> community job | <input type="checkbox"/> state MHI |
| <input type="checkbox"/> private residence/household – living with relatives | <input type="checkbox"/> school | <input type="checkbox"/> state resource center |
| <input type="checkbox"/> private residence/household – living with unrelated persons | <input type="checkbox"/> day program | <input type="checkbox"/> correctional facility / jail |
| <input type="checkbox"/> community supervised living | <input type="checkbox"/> work activity | <input type="checkbox"/> foster care/family life home |
| <input type="checkbox"/> RCF | <input type="checkbox"/> homeless/shelter/street | <input type="checkbox"/> ICF / nursing facility |
| <input type="checkbox"/> RCF/MR | <input type="checkbox"/> vehicle | <input type="checkbox"/> ICF/MR |
| <input type="checkbox"/> RCF/PMI | <input type="checkbox"/> shopping | <input type="checkbox"/> ICF/PMI |
| <input type="checkbox"/> assisted living | <input type="checkbox"/> dining | <input type="checkbox"/> hospital / medical clinic |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> recreating | <input type="checkbox"/> other _____ |
| | <input type="checkbox"/> other _____ | |

Fields in the **Incident Information** section of the Initial Report include information on the location where the incident occurred. There are three possible responses:

MEMBER'S HOME**COMMUNITY****OTHER LOCATION**

Select only one. After choosing one location, provide additional information on that location by selecting more specific choices under the location.

MEMBER'S HOME

- **PRIVATE RESIDENCE/HOUSEHOLD – LIVING ALONE:** - “Private household” means a dwelling unit occupied exclusively by the member and furnished by and belonging to them by reason of ownership, rental, or by a contract for purchase of life estate.
- **PRIVATE RESIDENCE/HOUSEHOLD – LIVING WITH RELATIVES:** - “Private household” means a dwelling unit occupied by people related to each other and furnished by and belonging to them by reason of ownership, rental, or by a contract for purchase of life estate. “Relatives” means a person or persons, who constitute the members of the household and are related to one another by kinship of blood, marriage, or adoption.
- **PRIVATE RESIDENCE/HOUSEHOLD – LIVING WITH UNRELATED PERSONS:** - “Private household” means a dwelling unit occupied by people unrelated to each other and furnished by and belonging to them by reason of ownership, rental, or by a contract for purchase of life estate.
- **COMMUNITY SUPERVISED LIVING:** - A building or place which provides residential and/or support services which would not constitute a private household and is not licensed through the Iowa Department of Inspections and Appeals.
- **RCF:** - A residential care facility licensed by the Iowa Department of Inspections and Appeals.
- **RCF/MR:** - A residential care facility for the mentally retarded licensed by the Iowa Department of Inspections and Appeals.
- **RCF/PMI:** - A residential care facility for the mentally ill licensed by the Iowa Department of Inspections and Appeals.
- **ASSISTED LIVING:** - An assisted living facility licensed by Iowa Department of Inspections and Appeals.
- **OTHER:** - Select and describe in the narrative box.

COMMUNITY

- **COMMUNITY JOB:** - Unsupported employment in the community or supported employment with individualized services associated with obtaining and maintaining competitive paid employment for individuals.
- **SCHOOL:** - An institution for the instruction of children or adults.
- **DAY PROGRAM:** - Organized program of supportive care in a group environment.
- **WORK ACTIVITY:** - Organized program of prevocational and work related activities in a group environment.

- **HOMELESS/SHELTER/STREET:** - Lacking permanent housing or an establishment that provides temporary housing for the homeless.
- **VEHICLE:** - A conveyance moving on wheels, runners, tracks, or the like, as a cart, sled, automobile, or tractor.
- **SHOPPING:** - Visiting shops and stores for purchasing or examining goods.
- **DINING:** - Eating a meal away from home as in a restaurant.
- **RECREATING:** - A pastime, diversion, exercise, or other resource affording relaxation and enjoyment.
- **OTHER:** - Select and describe in the narrative box.

OTHER LOCATION

- **STATE MHI:** - State Mental Health Institutes in Cherokee, Clarinda, Independence and Mount Pleasant.
- **STATE RESOURCE CENTER:** - Glenwood and Woodward State Resource Centers.
- **CORRECTIONAL FACILITY / JAIL:** - A place for the confinement of persons in lawful detention.
- **FOSTER CARE/FAMILY LIFE HOME:** - “Foster care” means a single-family living unit in which an individual or a married couple or a licensed facility provide room, board, and care for a child for a period exceeding 24 consecutive hours. “Family-life home” means a private household offering a protective social living arrangement for one or two eligible adults who are not able or willing to adequately maintain themselves in an independent living arrangement, but who are essentially capable of physical self-care.
- **ICF / NURSING FACILITY:** - Intermediate care (nursing) facility.
- **ICF/MR:** - Intermediate care (nursing) facility for the mentally retarded.
- **ICF/PMI:** - Intermediate care (nursing) facility for the mentally ill.
- **HOSPITAL / MEDICAL CLINIC:** - Facilities in which sick or injured persons are given medical treatment on an inpatient and/or outpatient basis.
- **OTHER:** - Select and describe in the narrative box.

Figure 6: *Others Present*, Part 1 Initial Report

| Other People Present (Provide name of person, initials if a member, and their relationship to the member) | | | | | | | |
|---|---------------------------------------|--------------------------------|---------------------------------|-----------------------------------|-----------------------------------|---|--|
| 1. _____ | <input type="checkbox"/> other member | <input type="checkbox"/> staff | <input type="checkbox"/> family | <input type="checkbox"/> roommate | <input type="checkbox"/> neighbor | <input type="checkbox"/> other, specify _____ | |
| 2. _____ | <input type="checkbox"/> other member | <input type="checkbox"/> staff | <input type="checkbox"/> family | <input type="checkbox"/> roommate | <input type="checkbox"/> neighbor | <input type="checkbox"/> other, specify _____ | |
| 3. _____ | <input type="checkbox"/> other member | <input type="checkbox"/> staff | <input type="checkbox"/> family | <input type="checkbox"/> roommate | <input type="checkbox"/> neighbor | <input type="checkbox"/> other, specify _____ | |
| 4. _____ | <input type="checkbox"/> other member | <input type="checkbox"/> staff | <input type="checkbox"/> family | <input type="checkbox"/> roommate | <input type="checkbox"/> neighbor | <input type="checkbox"/> other, specify _____ | |

Fields in the **Incident Information** section of the Initial Report include information on other people who were present at the time the incident occurred. Enter the names of all provider staff present at the time of the incident or who responded after becoming aware of the incident in the narrative box. The confidentiality of other members or non-members who were present must be maintained by the use of initials.

- **OTHER MEMBER:** - Medicaid member accessing any level or type of services.
- **STAFF:** - An individual or group of persons employed by the provider to perform specific tasks.
- **FAMILY:** - A person or persons who are related to the member by kinship of blood, marriage, or adoption.
- **ROOMMATE:** - A person with whom the member shares a room or living space.
- **NEIGHBOR:** - A person who lives near or next to the member.
- **OTHER:** - Select and specify the relationship in the narrative box.

Figure 7: *Services Being Provided*, Part 1 Initial Report

| | |
|---|--------------------|
| Services: (select one) | |
| <input type="checkbox"/> Services were not being provided. | |
| <input type="checkbox"/> Service being provided at the time of the incident: W code _____ | Service Name _____ |

Fields in the **Incident Information** section of the Initial Report include information on the services which were being provided at the time the incident occurred.

- **SERVICES WERE NOT BEING PROVIDED:** - Select this checkbox if services were **not** being provided at the time the incident occurred.
- **SERVICES WERE BEING PROVIDED AT THE TIME OF THE INCIDENT:** - Select this checkbox if services were being provided at the time the incident occurred. Indicate the procedure code in the **W CODE** narrative box and provide the **SERVICE NAME** of the service being provided in the narrative box.

Figure 8: *Narrative of Incident*, Part 1 Initial Report

Fields in the **Incident Information** section of the Initial Report require a written narrative of the incident being reported. Describe what happened before the incident including environmental conditions and any cues given. Describe the incident in observable and measureable terms. Describe what occurred after the incident and how long the incident lasted.

Figure 9: *Immediate Resolution*, Part 1 Initial Report

| | | | |
|-----------------------------|---|--|--|
| Immediate Resolution | Date of Immediate Resolution: _____ | | |
| | Type of Immediate Resolution: (select all that apply) | | |
| | <input type="checkbox"/> resolved by provider staff | <input type="checkbox"/> in-patient hospitalization (medical unit) | <input type="checkbox"/> resolved by case manager |
| | <input type="checkbox"/> incarceration | <input type="checkbox"/> resolved by outside entity | <input type="checkbox"/> resolved by natural supports |
| | <input type="checkbox"/> out-patient mental health | <input type="checkbox"/> treatment by a health care professional | <input type="checkbox"/> emergency room treatment |
| | | | <input type="checkbox"/> in-patient hospitalization (mental health unit) |
| | Describe the actions taken after the incident occurred to secure the member's safety. | | |
| | Guardian: <input type="checkbox"/> yes <input type="checkbox"/> no Guardian notified: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> attempted, unable to reach | | |

Fields in the **Incident Information** section of the Initial Report require information on the immediate resolution of the incident, specifically the assurance of health and safety for all persons involved. There are ten resolution factors listed. Select all that apply.

- **DATE OF IMMEDIATE RESOLUTION:** - Enter the date that the health and safety of all persons involved was assured.
- **RESOLVED BY PROVIDER STAFF:** - Staff actions to immediately protect person(s) from harm, to assure that the environment was safe, to provide first aid or seek emergency medical attention and to notify a supervisor.
- **INCARCERATION:** - Confined in lawful detention by law enforcement officers.
- **OUT-PATIENT MENTAL HEALTH:** - The treatment, assessment, or counseling of the member for a cognitive, behavioral, emotional, mental or social dysfunction in other than an in-patient setting.

- **IN-PATIENT HOSPITALIZATION (MEDICAL UNIT):** - Emergency inpatient hospitalization of the member for unplanned medical procedures, including but not limited to: surgery, medical observation or testing.
- **RESOLVED BY OUTSIDE ENTITY:** - Resolution by a person for whom the member has no connection, association or involvement such as a bystander.
- **TREATMENT BY A HEALTH CARE PROFESSIONAL:** - Any unplanned visit to a clinic or medical professional by the member for treatment of an injury, illness or medical condition.
- **RESOLVED BY CASE MANAGER:** - Resolution by the targeted case manager, HCBS case manager, or IDHS social worker who is assigned oversight and monitoring of the member's plan of care.
- **RESOLVED BY NATURAL SUPPORTS:** - Resolution by a person or persons in the community who provide supportive relationships such as a family member, classmates, peers, co-workers, places of business, religious organization, and community programs.
- **EMERGENCY ROOM TREATMENT:** - Emergency room treatment of the member for an injury, illness or medical condition for unplanned medical procedures, including but not limited to: observation, medical procedures or testing.
- **IN-PATIENT HOSPITALIZATION (MENTAL HEALTH UNIT):** - Any unplanned admission to a medical facility by the member for treatment of a psychiatric condition.
- **DESCRIBE THE ACTIONS TAKEN AFTER THE INCIDENT OCCURRED TO SECURE THE MEMBER'S SAFETY:** - Under actions taken, staff will describe all actions taken to respond to or remediate the incident. Describe:
 1. Any staff actions to immediately protect the member or others from harm;
 2. Any immediate staff actions to make the environment safe;
 3. Any actions to provide first aid or seek emergency medical assistance; and
 4. Identify supervisors and/or other persons notified of the incident.
- **GUARDIAN:** - Guardian means the person appointed by the court to have custody of the member (or ward) under provisions of the Probate Code. (Iowa Code Chapter 633), or the parent of a minor child. Indicate if the guardian was notified of the incident.

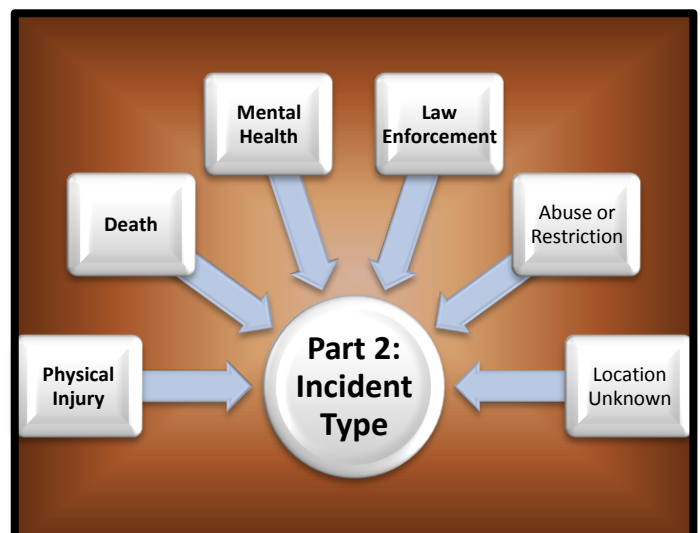
THIS IS THE END OF PART 1. THIS INFORMATION MUST BE SUBMITTED BY THE END OF THE NEXT CALENDAR DAY FOLLOWING THE INCIDENT VIA THE IMPA OR FAXED PAPER FORM

PART 2 – INCIDENT TYPE

Part 2 gathers information on the specific type of incident which has occurred. There are six categories of incident types. Select all that apply.

Part 2 may be completed with Part 1, or providers may conduct an internal investigation consisting of interviews and documentation review before completing Part 2.

Best practices recommend that an incident report be completed and submitted up to seven calendar days following an incident. If sections 2, 3 and 4 cannot be completed because necessary investigative activities are not yet complete and / or resolution activities have not been implemented, then the incident resolution should be updated and completed within 30 calendar days following the incident.



PHYSICAL INJURY

Figure 10: Physical Injury, Part 2 Incident Type

| CRITICAL INCIDENT REPORT | | |
|--|--|---|
| Physical Injury <input type="checkbox"/> | (Please note: Complete the Circumstances section and Physical Injury Type before completing the Injury due to: section.) | |
| | Circumstances: (select one) Physical injury occurred <input type="checkbox"/> to the member <input type="checkbox"/> by the member to another individual. | |
| | Physical Injury Type: Physical injury requiring physician's treatment or admission to a hospital. (select all that apply) <input type="checkbox"/> burn <input type="checkbox"/> dislocation <input type="checkbox"/> sprain <input type="checkbox"/> allergic reaction <input type="checkbox"/> concussion <input type="checkbox"/> contusion / bruise <input type="checkbox"/> human/animal bite <input type="checkbox"/> abrasion <input type="checkbox"/> laceration <input type="checkbox"/> puncture wound <input type="checkbox"/> fracture <input type="checkbox"/> electric shock <input type="checkbox"/> eye emergency <input type="checkbox"/> loss/tearing of body part <input type="checkbox"/> loss of consciousness <input type="checkbox"/> poisoning/toxin ingestion <input type="checkbox"/> other _____ | Injury due to: (select all that apply) <input type="checkbox"/> Mechanical restraint <input type="checkbox"/> mechanical restraint for behaviors <input type="checkbox"/> removal of mobility aids <input type="checkbox"/> impair sensory capabilities <input type="checkbox"/> other, describe _____ <input type="checkbox"/> Personal harm <input type="checkbox"/> aggressive behavior <input type="checkbox"/> self-mutilation / self injurious behavior <input type="checkbox"/> suicide attempt <input type="checkbox"/> PICA behavior / ingestion of harmful substance <input type="checkbox"/> accidental fall <input type="checkbox"/> aspiration / choking <input type="checkbox"/> seizure <input type="checkbox"/> vehicular accident <input type="checkbox"/> assault <input type="checkbox"/> other; describe _____ <input type="checkbox"/> Medication variance by staff <input type="checkbox"/> wrong dosage <input type="checkbox"/> wrong medication <input type="checkbox"/> wrong time <input type="checkbox"/> documentation error <input type="checkbox"/> unauthorized administration <input type="checkbox"/> missed dosage <input type="checkbox"/> other, describe _____ |
| | | <input type="checkbox"/> Physical / manual restraint <input type="checkbox"/> movement inhibited <input type="checkbox"/> take down <input type="checkbox"/> prone restraint <input type="checkbox"/> other, describe _____ <input type="checkbox"/> Environmental condition <input type="checkbox"/> fire <input type="checkbox"/> tornado / storm <input type="checkbox"/> flooding <input type="checkbox"/> unsafe/ unhealthy physical environment <input type="checkbox"/> social / familial dysfunction <input type="checkbox"/> other, describe _____ <input type="checkbox"/> Medication variance by member <input type="checkbox"/> wrong dosage <input type="checkbox"/> wrong medication <input type="checkbox"/> wrong time <input type="checkbox"/> unauthorized administration <input type="checkbox"/> missed dosage <input type="checkbox"/> other, describe _____ |

The Physical Injury section of the **Incident Type** consists of three steps. First, the reporter indicates whether the physical injury occurred to the member or by the member to another individual. Second, the specific type of injury is checked. Remember that the injury must require a physician's treatment or admission to a hospital. If the member is taken for medical treatment but the health care professional does not indicate that an injury has occurred then the incident does not meet the requirements for a physical injury. If this is the case, do not complete the second step of the Physical Injury section. Proceed on to other incident types.

Step 3 of the physical injury section identifies specific factors surrounding the physical injury and will be explained later in this guide.

Figure 11: *Physical Injury Circumstance*, Part 2 Incident Type

| |
|--|
| (Please note: Complete the Circumstances section and Physical Injury Type before completing the Injury due to: section.) |
| Circumstances: (select one) Physical injury occurred <input type="checkbox"/> to the member <input type="checkbox"/> by the member to another individual. |

Complete the **Circumstances** part by indicating whether the physical injury occurred to the member or was caused by the member to another individual. Completion of this part is required before proceeding to the description of the injury. Select only one.

Figure 12: *Physical Injury, Part 2 Incident Type*

Physical Injury Type:

Physical injury requiring physician's treatment or admission to a hospital.
(select all that apply)

- ☐ burn
- ☐ dislocation
- ☐ sprain
- ☐ allergic reaction
- ☐ concussion
- ☐ contusion / bruise
- ☐ human/animal bite
- ☐ abrasion
- ☐ laceration
- ☐ puncture wound
- ☐ fracture
- ☐ electric shock
- ☐ eye emergency
- ☐ loss/tearing of body part
- ☐ loss of consciousness
- ☐ poisoning/toxin ingestion
- ☐ other _____

Fields in Step 2 of the **Physical Injury** section of the Incident Type includes the following selections. Please select all that apply.

- **BURN:** - An injury usually caused by heat but also by abnormal cold, chemicals, poison gas, electricity, or lightning, and characterized by a painful reddening and swelling of the epidermis (first-degree burn), damage extending into the dermis, usually with blistering (second-degree burn), or destruction of the epidermis and dermis extending into the deeper tissue with loss of pain receptors (third-degree burn).
- **DISLOCATION:** - Displacement of a body part, especially the temporary displacement of a bone from its normal position.
- **SPRAIN:** - The condition resulting from a sprain that is usually marked by swelling, inflammation, hemorrhage, and discoloration. The sprain is caused by a sudden or violent twist or wrench of a joint causing the stretching or tearing of ligaments. The tearing of muscle fibers or tendons (strain) due to overstretching would also fit under this category.
- **ALLERGIC REACTION:** - A local or generalized reaction to internal or external contact with a specific foreign substance, such as a protein or a drug, after a preliminary or sensitizing exposure. An allergic reaction may manifest as a sharp drop in blood pressure, hives, rash or swelling of tissue, and breathing difficulties.
- **CONCUSSION:** - An injury to a soft structure, especially the brain, produced by a violent blow or impact and followed by a temporary, sometimes prolonged, loss of function. A concussion of the brain results in transient loss of consciousness or memory.
- **CONTUSION / BRUISE:** - An injury in which the skin is not broken, often characterized by ruptured blood vessels and discolorations; a bruise.
- **HUMAN / ANIMAL BITE:** - A bite is a wound received from the mouth (and

in particular, the teeth) of an animal, including humans.

- **ABRASION:** - The rubbing or scraping of the surface layer of cells or tissue from an area of the skin or mucous membrane.
- **LACERATION:** - The process or act of tearing tissue such as a jagged wound or cut requiring sutures, use of derma bond, or staples.
- **PUNCTURE WOUND:** - A wound that is deeper than it is wide, produced by a narrow pointed object.
- **FRACTURE:** - A rupture, break, or crack, especially in bone or cartilage.
- **ELECTRIC SHOCK:** - The sudden stimulation of the nerves or convulsive contraction of the muscles accompanied by a feeling of concussion that is caused by the discharge through the body of electricity from a charged source.
- **EYE EMERGENCY:** - Cuts, scratches, objects in the eye, burns, chemical exposure, and blunt injuries to the eye or eyelid. Since the eye is easily damaged, any of these conditions can lead to vision loss if left untreated.
- **LOSS / TEARING OF BODY PART:** - Complete or partial traumatic amputation of a body part -- usually a finger, toe, arm, or leg -- that occurs as the result of an accident or trauma.
- **LOSS OF CONSCIOUSNESS:** - A state of impaired consciousness in which one shows no responsiveness to environmental stimuli but may respond to deep pain with involuntary movements.
- **POISONING / TOXIN INGESTION:** - Any substance taken internally or applied externally that is injurious to health or dangerous to life.
- **OTHER:** - Select and describe the physical injury in the narrative box.

Figure 13: *Physical Injury Due to a Mechanical Restraint, Part 2 Incident Type*

☐ Mechanical restraint
☐ mechanical restraint for behaviors
☐ removal of mobility aids
☐ impair sensory capabilities
☐ other, describe _____

Step 3 of **Physical Injury** identifies the factors contributing to the injury. Please select all that apply. **MECHANICAL RESTRAINT** means a device attached or adjacent to the member's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.

The following **are not considered** mechanical restraints for the purpose of this guide:

- Devices used to provide support for the achievement of functional body positions and equilibrium that have been prescribed by an appropriate health care professional;
- Stretcher belts, one piece safety belts, rail safety belts and transportation safety belts intended to prevent the member from accidentally falling;
- Equipment that does not restrict or prevent movement or the normal use/functioning of the body or body parts to which it is applied;
- Mechanical supports to provide stability necessary for therapeutic measures, such as immobilization of fractures, administration of intravenous or other medically necessary procedures; and/or
- Car seats, high chairs, playpens or items generally used by parents and considered to be used for a child's general health and safety do not fall into this category, unless abuse, neglect or exploitation are suspected.

Fields in the **Physical Injury due to a Mechanical Restraint** section of the Incident Type include:

- **MECHANICAL RESTRAINT FOR BEHAVIORS:** - Any use of a mechanical device attached to or in contact with the member's body to restrict access to his or her body or to the environment to prevent or intervene with a challenging behavior.
- **REMOVAL OF MOBILITY AIDS:** - Removing the member's mobility aids (wheelchairs, walkers, etc.) to prohibit freedom/choice of movement.
- **IMPAIR SENSORY CAPABILITIES:** - Mechanical restraints that impair or inhibit visual or auditory capabilities or prevent, inhibit, or impair speech or other communication modalities.
- **OTHER:** - Select and describe the mechanical restraint in the narrative box.

Figure 14: *Physical Injury Due to a Physical / Manual Restraint, Part 2 Incident Type*

PHYSICAL / MANUAL RESTRAINT is the use of any physical or manual intervention used to restrict movement of the member including, but not limited to, holding the member's body or limb(s) contingent upon behavior, or using an approved manual restraint procedure (e.g. Mandt technique) so that movement is restricted or prevented for any amount of time. Please select all that apply.

☐ Physical / manual restraint
☐ movement inhibited
☐ take down
☐ prone restraint
☐ other, describe _____

For the purposes of this guide, the following **are not considered** physical / manual restraints:

- Holding the member's limb(s) or body to provide support for the achievement of functional body positions and equilibrium that have been prescribed by an appropriate health care professional;
- Holding a member's limb(s) or body as part of a specific medical, dental or surgical procedure that have been authorized by an appropriate health care professional; and/or
- Holding a member's limb(s) or body to prevent the member from accidentally falling.

Fields in the **Physical Injury Due to a Physical / Manual Restraint** section of the Incident Type include:

- **MOVEMENT INHIBITED:** - Any restriction of physical movement in which the member remains on their feet or in a seated position for the purposes of controlling aggressive or agitated behavior.
- **TAKE DOWN:** - Gripping, handling and controlling of a member to bring the member into submission for the purpose of gaining quick control due to aggression or agitation.
- **PRONE RESTRAINT:** - Physical holding of the member in a prone position, usually on the floor, for the purpose of gaining quick control due to aggression or agitation. Prone restraint is the extended restraint past the time of immediate struggle.
- **OTHER:** - Select and describe the mechanical restraint in the narrative box.

Figure 15: *Physical Injury Due to Personal Harm, Part 2 Incident Type*

☐ Personal harm
☐ aggressive behavior
☐ self-mutilation / self injurious behavior
☐ suicide attempt
☐ PICA behavior / ingestion of harmful substance
☐ accidental fall
☐ aspiration / choking
☐ seizure
☐ vehicular accident
☐ assault
☐ other; describe _____

Please select all that apply. Fields in the **Personal Harm** section of the Incident Type include:

- **AGGRESSIVE BEHAVIOR:** - Overt or suppressed hostility, either innate or resulting from continued frustration and directed outward or against oneself. Hostile or destructive behavior or actions.
- **SELF-MUTILATION / SELF-INJURIOUS BEHAVIOR:** - Behaviors that are harmful to oneself, including deliberate self-injury, such as hitting, oneself, or behaviors that indirectly cause injury or harm, such as repeatedly rubbing an area of skin until it bleeds.

- **SUICIDE ATTEMPT:** - The member's verbal,

non-verbal or written threat to kill him/herself. An incident involving an act (attempt) to harm, injure or kill oneself.

- **PICA BEHAVIOR / INGESTION OF HARMFUL SUBSTANCE:** - Swallowing and/or ingesting substances that are non-food and potentially threatening to the health of the member, e.g., plants, poison, lotions, coins, paper clips, cigarette butts (PICA behavior).
- **ACCIDENTAL FALL:** - Happening by chance or accident; not planned; unexpected. The act or instance of falling or dropping from a higher to a lower place or position.
- **INGESTED / ASPIRATION / CHOKING:** - The inhaling of food or other object in the lung (aspiration) or choking.
- **SEIZURE:** - A sudden attack, spasm, or convulsion, as in epilepsy.
- **VEHICULAR ACCIDENT:** - When a road vehicle collides with another vehicle, pedestrian, animal, or geographical or architectural obstacle. Any vehicular accident involving the member.
- **ASSAULT:** - A violent physical or verbal attack. Threatening or attempting to inflict immediate bodily harm that a person has the ability to inflict and that puts the victim in fear of such harm or contact.
- **OTHER:** - Select and describe the personal harm in the narrative box.

Figure 16: *Physical Injury Due to an Environmental Condition, Part 2 Incident Type*

Please select all that apply. Fields in the **Environmental Condition** section of the Incident Type include:

- **FIRE:** - Environmental hazards that place the member in immediate jeopardy due to a fire.
- **TORNADO / STORM:** - Environmental hazards that place the member in immediate jeopardy due to severe weather such as a thunderstorm or tornado.
- **FLOODING:** - Environmental hazards that place the

☐ Environmental condition
☐ fire
☐ tornado / storm
☐ flooding
☐ unsafe / unhealthy physical environment
☐ social / familial dysfunction
☐ other; describe _____

member in immediate jeopardy due to flooding.

- **UNSAFE / UNHEALTHY PHYSICAL ENVIRONMENT:** - Any edifice or space which does not provide a safe and healthy environment. Conditions include, but not limited to, excess cold, excess heat, mold, pollutants, poor or inadequate sanitation or water supply, food safety, and environmental hazards such as electrical or gas.
- **SOCIAL ENVIRONMENT:** - Hazards from the social environment, which is the culture that the member was educated and/or lives in, and the people and institutions with whom the member interacts. Social environment concerns would include familial and interpersonal relationship dysfunctions which jeopardize the health and welfare of the member.
- **OTHER:** - Select and describe the personal harm in the narrative box.

Figure 17: *Physical Injury Due to a Medication Variance by Staff*, Part 2 Incident Type

Please select all that apply. Fields in the **Medication Variance by Staff** section of the Incident Type include:

- **WRONG DOSAGE:** - Incorrect dose, dosage form, quantity, route, concentration and / or rate of administration.
- **WRONG MEDICATION:** - Incorrect drug selection, contraindications, known allergies, and / or harmful interaction with existing drug therapy.
- **WRONG TIME:** - Medication administered early or late; and/or medication administered outside a predefined time interval from its scheduled administration time.
- **DOCUMENTATION ERROR:** - Includes but is not limited to:
 1. Incorrect documentation of medication orders, e.g. label on bottle does not match information on the Medication Administration Record (MAR);
 2. Administering medication but failing to document the MAR correctly;
 3. Failure to follow other agency procedures for medication administration; and/or
 4. Medication administered by unauthorized and/or improperly trained staff.
- **UNAUTHORIZED ADMINISTRATION:** - Includes but is not limited to:
 1. Administration of a drug that has expired or for which the physical or chemical dose (integrity of the drug) has been compromised; and/or
 2. Member's refusal to take the medication and follow medication regimen.
 3. Medication not authorized by a physician for the member;
 4. Medication given to the wrong person;
 5. Administering medication beyond a "stop order"; and/or
 6. Administering medication prescribed to treat behaviors without consent from the parent or guardian.
- **MISSED DOSAGE:** - Medications not administered because the medication was omitted, sufficient quantities were not available, or prescriptions not filled within a reasonable amount of time; and/or the failure to administer a prescribed medication for one or more dosage periods.
- **OTHER:** - Select and describe the medication variance by staff in the narrative box.

Figure 18: *Physical Injury Due to a Medication Variance by the Member*, Part 2 Incident Type

Please select all that apply. Fields in the **Medication Variance by the Member** section of the Incident Type include:

- **WRONG DOSAGE:** - Incorrect dose, dosage form, quantity, route, concentration and / or rate of administration.
- **WRONG MEDICATION:** - Incorrect drug selection, contraindications, known allergies, and / or harmful interaction with existing drug therapy.

- **WRONG TIME:** - Medication administered early or late; and/or medication administered outside a predefined time interval from its scheduled administration time.
- **UNAUTHORIZED ADMINISTRATION:** - Includes but not limited to:
 1. Self-administration of a drug that has expired or for which the physical or chemical dose (integrity of the drug) has been compromised; and/or
 2. Member's refusal to take the medication and follow medication regimen.
 3. Medication not authorized by a physician for the member;
 4. Medication given to another person;
 5. Self-administering medication beyond a "stop order"; and/or
 6. Self-administering medication prescribed to treat behaviors without consent from the parent or guardian.
- **MISSED DOSAGE:** - Medications not self-administered because the medication was omitted, sufficient quantities were not available, or prescriptions not filled within a reasonable amount of time; and/or the failure to administer a prescribed medication for one or more dosage periods.
- **OTHER:** - Select and describe the medication variance by the member in the narrative box.

DEATH

Figure 19: Death, Part 2 Incident Type

| | | | |
|--|--|--|---|
| Death <input type="checkbox"/> | Apparent cause of death: (select one) <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide / violence <input type="checkbox"/> terminal illness / natural causes <input type="checkbox"/> physical injury condition / situation <input type="checkbox"/> other; describe _____ | Member's location at time of death: (select one) <input type="checkbox"/> member's legal residence <input type="checkbox"/> community <input type="checkbox"/> community job <input type="checkbox"/> school <input type="checkbox"/> crisis stabilization <input type="checkbox"/> day program <input type="checkbox"/> work activity <input type="checkbox"/> state facility <input type="checkbox"/> hospital / clinic <input type="checkbox"/> hospice <input type="checkbox"/> other; describe _____ | Physical address where the member died: Address: _____ City: _____ State _____ Zip _____ Physical illnesses/conditions were: <input type="checkbox"/> diagnosed prior to death <input type="checkbox"/> discovered at time of death <input type="checkbox"/> unknown |
| | <input type="checkbox"/> Death of person other than member: Name _____ Relationship to member: _____ Specifically, what were the circumstances surrounding death? _____ | Complete if known: Was an autopsy requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Was there a DNR order? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

The Death reporting section of the **Incident Type** gathers information about the apparent cause, the location, and narrative surrounding the member's death.

Figure 20: Apparent Cause of Death, Part 2 Incident Type

Please select only one cause of death. For the purposes of this guide, **DEATH** is defined as all loss of life, regardless of cause. Fields in the **Apparent Cause of Death** section of the Incident Type include:

- **ACCIDENT:** - An accident is a specific, identifiable, unexpected, unusual and unintended external action which occurs in a particular time and place, without apparent or deliberate cause but with marked effects.
- **SUICIDE:** - Intentional taking of one's own life.
- **HOMICIDE / VIOLENCE:** - Death caused by the willful action of another.
- **TERMINAL ILLNESS / NATURAL CAUSES:** - Any death caused by a long-term illness, a diagnosed chronic medical condition, or other natural / expected conditions resulting in death.

| |
|--|
| Apparent cause of death: (select one) <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide / violence <input type="checkbox"/> terminal illness / natural causes <input type="checkbox"/> physical injury condition / situation <input type="checkbox"/> other; describe _____ |
| <input type="checkbox"/> Death of person other than member: Name _____ Relationship to member: _____ |

- **CONDITION / SITUATION IDENTIFIED UNDER PHYSICAL INJURY:** - Refer to the physical injury definitions. If this is selected, there must be a corresponding selection under physical injuries.
- **OTHER:** - Select and describe apparent cause of death in the narrative box.

Figure 21: Location of Death, Part 2 Incident Type

Please select only one location of death. Fields in the **Location of Death** section of the Incident Type include:

- **MEMBER'S LEGAL RESIDENCE:** - The address of the member's primary resident. This must be a physical address, not a post office box.
- **COMMUNITY:** - A particular place or region where the member lives, works and/or recreates.
- **COMMUNITY JOB:** - Unsupported employment in the community or supported employment with individualized services associated with obtaining and maintaining competitive paid employment for individuals.
- **SCHOOL:** - An institution for the instruction of children or adults.
- **CRISIS STABILIZATION:** - Emergency psychiatric care provided on an in-patient or out-patient basis.
- **DAY PROGRAM:** - Organized program of supportive care in a group environment.
- **WORK ACTIVITY:** - Organized program of prevocational and work related activities in a group environment.
- **STATE FACILITY:** - A state mental health institute at Cherokee, Clarinda, Independence and Mount Pleasant, or a state resource center at Glenwood and Woodward.
- **HOSPITAL / CLINIC:** - A facility in which sick or injured persons is given medical or surgical treatment on either an inpatient or outpatient basis.
- **HOSPICE:** - A health-care facility for the terminally ill.
- **OTHER:** - Select and describe the location in the narrative box.

Figure 22: Physical Address of Death, Part 2 Incident Type

Fields in the **Physical Address of Death** section of the Incident Type include:

- **PHYSICAL ADDRESS (ADDRESS, CITY, STATE, and ZIP):** - Enter the physical address where the death occurred including street address, city, state and zip.
- **PHYSICAL ILLNESSES / CONDITIONS DIAGNOSED PRIOR TO DEATH:** - Place a check in the box if there were physical illnesses or conditions present which contributed or caused the death to occur.
- **PHYSICAL ILLNESSES / CONDITIONS DISCOVERED AT TIME OF DEATH:** - Check this box if there were physical illness or conditions unknown before but discovered at the time of death.
- **PHYSICAL ILLNESSES / CONDITIONS UNKNOWN:** - If there were no physical illnesses or conditions present prior to death which were contributing factors and no physical illnesses or conditions were discovered at the time of death check this box.

Figure 23: Autopsy, Part 2 Incident Type

Fields in the **Autopsy** section of the Incident Type include:

- **AUTOPSY REQUESTED:** - Select the yes or no checkbox to indicate whether an autopsy was requested.
- **AUTOPSY PERFORMED:** - Select the yes or no checkbox to indicate whether an autopsy was performed.

- **DNR:** - Select the yes or no checkbox to indicate whether there was a Do Not Resuscitate order on file at the time of death.

Figure 24: Narrative of Death, Part 2 Incident Type

Specifically, what were the circumstances surrounding death?

The narrative of death section of **Incident Types** requires a written narrative of the death being reported. Include all pertinent information of the events preceding death.

EMERGENCY MENTAL HEALTH TREATMENT

Figure 25: Emergency Mental Health Treatment, Part 2 Incident Type

The Emergency Mental Health Treatment section of the **Incident Type** gathers information about mental health factors

| | |
|--|--|
| Mental Health <input type="checkbox"/> | Emergency mental health treatment due to: (select all that apply) <input type="checkbox"/> condition / situation identified under physical injury <input type="checkbox"/> condition / situation identified under law enforcement <input type="checkbox"/> suicidal ideation <input type="checkbox"/> self injurious / self mutilation behavior without physical injury <input type="checkbox"/> aggressive behavior toward another without physical injury <input type="checkbox"/> other, describe _____ |
|--|--|

which happened before or at the time of the incident. Please select all that apply. For the purposes of this guide, Emergency Mental Health Treatment is evaluative in nature and designed to create an accurate psychiatric diagnosis, to provide brief intervention when appropriate, and to establish or refer for treatment. Emergency Mental Health Treatment would include suicide and homicide risk assessments, mental status examinations and evaluation of the need for detoxification. Fields in the **Emergency Mental Health Treatment** section of the Incident Type include:

- **CONDITION / SITUATION IDENTIFIED UNDER PHYSICAL INJURY:** - Refer to the physical injury definitions. If this is selected, there must be a corresponding selection under physical injuries.
- **CONDITION / SITUATION IDENTIFIED UNDER LAW ENFORCEMENT:** - Refer to the intervention of law enforcement definitions. If this is selected, there must be a corresponding selection under law enforcement.
- **SUICIDAL IDEATION:** Wanting to take one's own life or thinking about self-harm. Having the intent to commit suicide, including planning how it will be done.
- **SELF INJURIOUS / SELF MUTILATION BEHAVIOR WITHOUT PHYSICAL INJURY:** Behavior that the member engages in that can cause physical bodily harm to themselves but which does not actually cause a physical injury as defined in the Physical Injury section.
- **AGGRESSIVE BEHAVIOR TOWARD ANOTHER WITHOUT PHYSICAL INJURY:** Hostile or destructive behavior or actions which can cause physical bodily harm to another but which does not actually cause a physical injury as defined in the Physical Injury section.
- **OTHER:** - Select and describe the emergency mental health treatment provided in the narrative box.

LAW ENFORCEMENT INTERVENTION

Figure 26: Law Enforcement Intervention, Part 2 Incident Type

| | |
|--|---|
| Law Enforcement <input type="checkbox"/> | Intervention of law enforcement for: (indicate whether the member was the victim or perpetrator and select all that apply) <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> illegal sexual behavior; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> possession of illegal / hazardous substances; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> inappropriate sexual advances; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> aggressive behavior; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator </div> <div style="width: 50%;"> <input type="checkbox"/> illegal acts; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> property damage; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> provoking incident; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> other; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator; describe _____ </div> </div> |
|--|---|

The Intervention of Law Enforcement section of the **Incident Type** gathers information about law enforcement factors which happened before or at the time of the incident. For the purposes of this guide, intervention of law enforcement is the arrest or detention of a person by law enforcement, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility. Select all that apply. For each choice selected indicate whether the member was the victim or the perpetrator.

VICTIM: - The member is considered the victim if they suffer from a destructive, injurious action or they are deceived and cheated by the dishonesty of another person or persons.

PERPETRATOR: - The member is considered the perpetrator if they are reasonably suspected, charged or convicted of being responsible for an illegal act.

Fields in the **Intervention of Law Enforcement** section of the Incident Type include:

- **ILLEGAL SEXUAL BEHAVIOR:** - Any incident involving the member where law enforcement has been contacted for:
 1. **SEXUAL ASSAULT:** Knowingly subjecting another person to any sexual contact without consent.
 2. **SEXUAL INTERCOURSE WITHOUT CONSENT:** Knowingly having sexual intercourse without consent with another person.
 3. **INDECENT EXPOSURE:** Knowingly or purposely exposing the person's genitals under circumstances in which the person knows the conduct is likely to cause affront or alarm in order to:
 - (a) Abuse, humiliate, harass, or degrade another; or
 - (b) Arouse or gratify the person's own sexual response or desire or the sexual response or desire of any person.
 4. **DEVIANT SEXUAL CONDUCT:** Knowingly engaging in deviant sexual relations or who causes another to engage in deviant sexual relations.
- **POSSESSION OF ILLEGAL / HAZARDOUS SUBSTANCES:** - Finding a person in possession of goods, merchandise or items that are prohibited or illegal. Examples may include, but are not limited to: weapons, drugs, drug paraphernalia or child pornography. This includes, any incident involving the use of or the discovery of illegal or hazardous substances or items, where the service provider has a duty to inform law enforcement due to possible criminal violations of law, e.g. discovery of illegal drugs/drug paraphernalia, weapons, etc.
- **INAPPROPRIATE SEXUAL ADVANCES:** - Any incident where law enforcement has been contacted involving a person knowingly subjecting another person to any sexual contact without consent.
- **AGGRESSIVE BEHAVIOR:** - Any incident involving the member where law enforcement has been contacted for overt or suppressed hostility, either innate or resulting from continued frustration and directed outward or against oneself. Hostile or destructive behavior or actions.
- **ILLEGAL ACTS:** - Any incident involving the member where law enforcement has been contacted for: Interventions where a person has engaged in, is suspected of engaging in, or is alleged to have engaged in, possible criminal acts including, but not limited to: theft; assault; arson; vandalism; trespassing; possession of illegal substances; weapon possession; fraud; calling 911 inappropriately.
- **PROPERTY DAMAGE:** - Any damage exceeding \$50.00 in cost to a person, agency, or community property by another, regardless of intent that may include, but not be limited to broken windows, damage to furniture, and/or damage to automobiles (not caused by vehicle accidents).
- **PROVOKING INCIDENT:** - Any incident involving a member where law enforcement has been contacted where the health and safety of a person is in question due to the actions of another.
- **OTHER:** - Select and describe the law enforcement intervention in the narrative box.

ABUSE REPORT OR RESTRICTION

Figure 27: Abuse Report or Restriction, Part 2 Incident Type

| | | |
|--|---|--|
| Abuse Report or Restriction <input type="checkbox"/> | Please specify member's involvement: Member was the <input type="checkbox"/> victim <input type="checkbox"/> perpetrator | Report of suspected dependent adult abuse (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> exploitation <input type="checkbox"/> sexual abuse <input type="checkbox"/> denial of critical care <input type="checkbox"/> self-denial of critical care |
| | Report of suspected child abuse (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> mental injury <input type="checkbox"/> sexual abuse <input type="checkbox"/> denial of critical care <input type="checkbox"/> presence of illegal drugs <input type="checkbox"/> manufacture or possession of a dangerous substance <input type="checkbox"/> cohabitation with a registered sex offender | Restriction or confinement (select all that apply) <input type="checkbox"/> arrest <input type="checkbox"/> as identified under physical injury <input type="checkbox"/> PRN meds for behavior <input type="checkbox"/> exclusionary timeout / isolation <input type="checkbox"/> seclusion <input type="checkbox"/> rights violation <input type="checkbox"/> cruel punishment |

The Abuse Report or Restrictions section of the **Incident Type** gathers information about:

CHILD ABUSE: - Verbal or written statement made to the Department by a person or persons who suspect that child abuse has occurred. (441 IAC 175.21)

DEPENDENT ADULT ABUSE: - Verbal or written statement made to the Department by a person or persons who suspect that dependent adult abuse has occurred. Dependent adult means a person 18 years of age or older who is unable to protect their own interests or unable to perform adequately or obtain services necessary to meet essential human needs, as a result of a physical or mental condition which requires assistance from another. (441 IAC 176.1)

RESTRICTION: - Rights restrictions means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom the individual using the service may share a residence. (441 IAC 24.1)

Select all that apply. For each category indicate whether the member was the victim or the perpetrator.

VICTIM: - The member is considered the victim if they suffer from a destructive, injurious action or they are deceived and cheated by the dishonesty of another person or persons.

PERPETRATOR: - The member is considered the perpetrator if they are reasonably suspected, charged or convicted of being responsible for an illegal act.

Figure 28: Suspected Child Abuse, Part 2 Incident Type

Fields in the **Abuse Report or Restrictions** section of the Incident Type include:

SUSPECTED CHILD ABUSE:

- **PHYSICAL INJURY:** - Any non-accidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the results of the acts or omissions of a person responsible for the care of the child. (Iowa Code section 232.68(2) (a)).
- **MENTAL INJURY:** - Any mental injury to a child's intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child's ability to function within that child's normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional. (Iowa Code section 232.68(2)(b))
- **SEXUAL ABUSE:** - The commission of sexual offense with or to a child pursuant to Iowa Code Chapter 709, section 726.2 or section 728.12, subsections 1, as a result of the acts or omissions of the person responsible for the care of the child. Notwithstanding Iowa Code section 702.5, the commission of a sexual offense under this

| |
|---|
| Please specify member's involvement: Member was the <input type="checkbox"/> victim <input type="checkbox"/> perpetrator |
| Report of suspected child abuse (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> mental injury <input type="checkbox"/> sexual abuse <input type="checkbox"/> denial of critical care <input type="checkbox"/> presence of illegal drugs <input type="checkbox"/> manufacture or possession of a dangerous substance <input type="checkbox"/> cohabitation with a registered sex offender |

paragraph includes any sexual offense referred to in this paragraph with or to a person under the age of 18 years. (Iowa Code section 232.68(2)(c)).

- **DENIAL OF CRITICAL CARE:** - The failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, or other care necessary for the child's health and welfare when financially able to do so, or when offered financial or other reasonable means to do so. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child. However, this provision does not preclude a court from ordering that medical service be provided to the child where the child's health requires it. (Iowa Code section 232.68(2)(d)).
- **PRESENCE OF ILLEGAL DRUGS:** - An illegal drug is present in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child. (Iowa Code section 232.68(2)(f))
- **MANUFACTURE OR POSSESSION OF A DANGEROUS SUBSTANCE:** - The person responsible for the care of a child:
 - Has manufactured a dangerous substance in the presence of the child, or
 - Possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, salts of optical isomers in the presence of the child with the intent to use the product as a precursor or an intermediary to a dangerous substance.
- **COHABITATION WITH A REGISTERED SEX OFFENDER:** - Abuse is committed when a caretaker of a child knowingly allows unsupervised access to a child by a person required to register on the sex offender registry or knowingly allows registered sex offender to have custody or control of a child. The finding of this type of abuse does not apply if:
 - The registered sex offender is the caretaker's child or a minor, or
 - The caretaker is married to and living with the registered sex offender.

For this type of abuse only, a "child" is a person under the age of 14 unless the child has a physical or mental disability.

Figure 29: Suspected Dependent Adult Abuse, Part 2 Incident Type

| | |
|---|--|
| Please specify member's involvement: Member was the <input type="checkbox"/> victim <input type="checkbox"/> perpetrator | Report of suspected dependent adult abuse (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> exploitation <input type="checkbox"/> sexual abuse <input type="checkbox"/> denial of critical care <input type="checkbox"/> self-denial of critical care |
|---|--|

Please select all that apply. Fields in the **Abuse Report or Restrictions** section of the Incident Type include **SUSPECTED DEPENDENT ADULT ABUSE** due to the willful or negligent acts or omissions of a caretaker:

- **PHYSICAL INJURY:** - Physical injury to, or injury which is at variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult.
- **SEXUAL ABUSE:** - The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 with or against a dependent adult.
- **SELF-DENIAL OF CRITICAL CARE:** - The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult.
- **EXPLOITATION:** - Exploitation of a dependent adult which means the act or process of taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit, without the informed consent of the dependent adult, including theft, by the use of undue influence, harassment, duress, deception, false representation, or false pretenses.
- **DENIAL OF CRITICAL CARE:** - The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care and other care necessary to maintain a dependent adult's life or health.

Figure 30: Restrictions, Part 2 Incident Type

Restriction or confinement (select all that apply)

- ☐ arrest
- ☐ as identified under physical injury
- ☐ PRN meds for behavior
- ☐ exclusionary timeout / isolation
- ☐ seclusion
- ☐ rights violation
- ☐ cruel punishment

Please select all that apply. Fields in the **Abuse Report or Restrictions** section of the Incident Type include **RESTRICTIONS**:

- **ARREST:** Member taken into legal custody by officers of the law.
- **AS IDENTIFIED UNDER PHYSICAL INJURY:**
- Refer to the physical injury definitions. If this is

selected, there must be a corresponding selection under physical injuries.

- **PRN MEDS FOR BEHAVIOR:** - Over the counter or prescribed medications or drugs that are administered to manage the member's behavior in a way that reduces the safety risk to themselves or to others and has the effect of reducing the member's freedom of movement, and that is not a standard treatment for the member's medical or psychiatric condition.
- **EXCLUSIONARY TIMEOUT:** - A method of decreasing a maladaptive target behavior by requiring the member to leave an ongoing reinforcing situation for a period of time, contingent on the occurrence of some previously specified maladaptive target behavior. Note: While the use of "time out" is a concern in adult services, time out is considered an accepted practice for good parenting and parents with children who exhibit challenging behavior are typically taught methods of appropriately implementing time out procedures as an alternative to the use of punishment. Therefore, the use of time out by a parent is not considered an incident under this guide unless abuse or neglect of the child is suspected.
- **SECLUSION / ISOLATION:** - Seclusion means the involuntary confinement or segregation of the member in a room or an area from which they are physically prevented from leaving or reasonably believe they will be prevented from leaving.
- **RIGHTS VIOLATION:** - Any action or inaction that deprives the member of the ability to exercise his or her legal rights, as articulated in state or federal law.
- **CRUEL PUNISHMENT:** - Any deliberate act of cruelty that endangers the physical or emotional well-being of the member. This includes the use of any aversive procedure including, but is not limited to the following:
 - Stimuli, activities, or sprays/inhalants that are, or may be considered noxious, intrusive, or painful;
 - Use of electric shock;
 - Water sprayed into the face;
 - Pinches and deep muscle squeezes;
 - Shouting, screaming or using a loud, sharp or harsh voice to frighten or threaten;
 - Use of obscene language;
 - Standing for an extended period of time;
 - Withholding of adequate sleep;
 - Withholding of adequate shelter or bedding;
 - Withholding bathroom facilities;
 - Withholding of warm clothes;
 - Withholding meals, essential nutrition or hydration; and/or
 - Use of facial or auditory screening devices;

LOCATION UNKNOWN

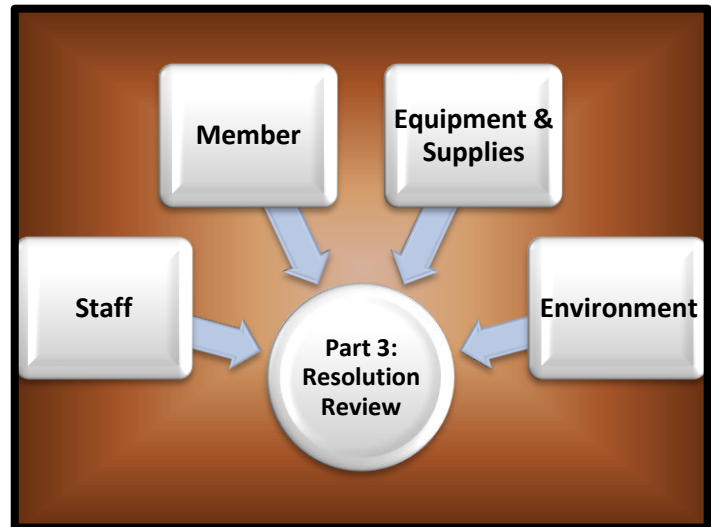
Figure 31: Location Unknown, Part 2 Incident Type

| | |
|---------------------|---|
| Location Unk | Member's location is unknown by provider responsible for protective oversight. Please describe: |
|---------------------|---|

Selection of the **LOCATION UNKNOWN** checkbox in the **Incident Information** section of the Initial Report requires a written narrative of the incident being reported. Include all pertinent information on the incident, including a description of the provider's responsibility for protective oversight.

PART 3 – INCIDENT-SPECIFIC RESOLUTION REVIEWS

Up till this point the incident report consists of a compilation of the information obtained from the provider's review of the incident and associated environmental and contributing factors discovered following an investigation of the incident. With this information, the provider can identify incident specific resolutions. **Please complete the appropriate resolution review which can be determined from the investigation of the incident.** It is not necessary to complete all four reviews. Complete the review or reviews which are appropriate. Part 3 captures information on these resolution reviews.



The four sections in **Part 3 Incident-specific Reviews** are:

STAFF REVIEW: - Incident-specific resolutions focused on staff and training factors.

MEMBER REVIEW: - Incident-specific resolutions focused on the actions, inactions, abilities, needs or goals of the member.

EQUIPMENT AND SUPPLIES REVIEW: - Incident-specific resolutions focused on the availability of adequate equipment or supplies.

ENVIRONMENTAL REVIEW: - Incident-specific resolutions focused on environmental circumstances.

STAFF REVIEW

Figure 32: Staff Review, Part 3 Resolution Review

| | | |
|---|--|--|
| Staff Review <input type="checkbox"/> | (Please note: Complete the Staff Review section only if staff issues contributed to the incident.) | |
| | Review staff: (select all that apply) | Provide staff training on: (select all that apply) |
| | <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> increase number of staff <input type="checkbox"/> increase staff hour <input type="checkbox"/> improve team building <input type="checkbox"/> increase supervision of staff </div> <div> <input type="checkbox"/> disciplinary action <input type="checkbox"/> change staff <input type="checkbox"/> terminate staff <input type="checkbox"/> other, describe: _____ </div> </div> | <input type="checkbox"/> rights <input type="checkbox"/> individual needs <input type="checkbox"/> behavioral needs <input type="checkbox"/> positive and supportive relationships <input type="checkbox"/> communication with member, family and/or other staff <input type="checkbox"/> staff trained / retrained on equipment use <input type="checkbox"/> other, describe: _____ |
| <input type="checkbox"/> Resolution following staffing review / training. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____ | | |
| <input type="checkbox"/> No staffing changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____ | | |

The Staff Review section identifies incident-specific resolutions focused on staff and training factors. Please select all that apply. Fields in the **Staff Review** section of the Incident-specific Resolutions include:

- **INCREASE NUMBER OF STAFF:** - Staff numbers increased to carry out the assigned duties in the expected timelines. The amount of work is consistent with the duties and assigned tasks.

- **INCREASE STAFF HOURS:** - Service hours were increased allowing staff to carry out the assigned duties. The amount of work is consistent with the duties and assigned tasks.
- **IMPROVE TEAM BUILDING:**
 - ☒ Staff are aware of whom they needed to work with to perform tasks and they work together as a team when required.
 - ☒ Staff have positive and mutually supportive relationships with other personnel.
 - ☒ Conflicts or poor relationships do not interfere with the ability of staff to properly complete assigned tasks in a safe and/or efficient manner.
 - ☒ Staff have incentives for performing the required activity, i.e., it was seen as important and acknowledged by the organization.
 - ☒ There are clear consequences for not completing assigned duties or activities.
 - ☒ Leaders are available to personnel.
 - ☒ There are established methods for sharing concerns or grievances.
- **INCREASE SUPERVISION OF STAFF:**
 - ☒ Staff or supervisors set priorities for multiple tasks and responsibilities.
 - ☒ Assumed priorities are consistent with organizational expectations.
 - ☒ Staff set aside sufficient time to perform priority tasks within expected timelines.
 - ☒ Staff are provided with consistent supervision from an assigned supervisor or peer network.
 - ☒ Staff have access to clear information re: the proper procedures or practices. Information is clear and easily located.
 - ☒ The table of organization or command structure is available and easy to understand.
 - ☒ Staff are not confused about who is responsible for what.
- **DISCIPLINARY ACTION:** - Staff who did not carry out duties and assigned tasks when adequately trained and supervised were the recipients of appropriate punitive measures.
- **CHANGE STAFF:** - Staff assignments were promptly changed when it was determined to be in the best interest of the member.
- **TERMINATE STAFF:** - Staff were promptly terminated from employment for not carrying out duties and assigned tasks.
- **OTHER:** - Select and describe the specific staff review in the narrative box.
- **PROVIDE STAFF TRAINING (RIGHTS):** - Staff have the necessary skills and knowledge to perform the assigned duties in a manner that does not infringe upon the member's rights.
- **PROVIDE STAFF TRAINING (INDIVIDUAL NEEDS):**
 - ☒ Staff have the necessary skills and knowledge to perform the assigned duties – staff know how to perform required tasks.
 - ☒ Staff are aware of what tasks they need to do and when those tasks are to be performed.
 - ☒ Staff have necessary experience to perform the task. If not experienced, they know whom to access for direction and support.
 - ☒ Staff have, or the record contains, adequate information re: any special risks, concerns or needs of the member.
- **PROVIDE STAFF TRAINING (BEHAVIORAL NEEDS):**
 - ☒ Staff have the necessary skills and knowledge to perform the assigned duties in the context of the member's behavioral needs.
 - ☒ Staff have the necessary experience performing the task in the context of the member's behavioral needs. If not experienced, they know whom to access for direction and support.
- **PROVIDE STAFF TRAINING (POSITIVE AND SUPPORTIVE RELATIONSHIPS):** - Staff have a positive and supportive relationship with the members they were assisting.
- **PROVIDER STAFF TRAINING (COMMUNICATION WITH MEMBER, FAMILY AND/OR OTHER STAFF):**
 - ☒ Staff have good communication with the member. Lack of adequate communication does not hinder awareness of a problem.

- ☒ There are adequate opportunities to communicate with the family or other knowledgeable persons.
- ☒ Good communication increases staff awareness of issues or risks.
- ☒ Staff communicate adequately with one another. Good communication increases awareness of risks or required activities.
- **PROVIDE STAFF TRAINING (TRAIN / RETRAIN ON EQUIPMENT USE):**
 - ☒ Staff have the necessary skills and knowledge to utilize equipment effectively.
 - ☒ Staff have the necessary experience utilizing equipment. If not experienced, they know whom to access for direction and support.
- **RESOLUTION FOLLOWING STAFFING AND/OR TRAINING REVIEW:** - Select this checkbox if any previous fields in this section were marked. Describe specifically how the incident-specific resolution will prevent or diminish the probability of future occurrences.
- **NO STAFFING OR TRAINING CHANGES REQUIRED:** - If no previous fields were selected then select this checkbox. Describe in the narrative box how this adverse incident was isolated with a minimal probability of reoccurrence.

MEMBER REVIEW

Figure 33: Member Review, Resolution Review

| | |
|----------------------|--|
| Member Review | (Please note: Complete the Member Review section only if member issues contributed to the incident.) |
| | Review member: (select all that apply) |
| | <input type="checkbox"/> treatment plan reviewed and/or revised due to behavioral issues <input type="checkbox"/> treatment plan reviewed and/or revised to reflect member's goals <input type="checkbox"/> treatment plan reviewed and/or revised due to cognitive abilities <input type="checkbox"/> treatment plan reviewed and/or revised due to communication needs <input type="checkbox"/> treatment plan reviewed and/or revised due to physical abilities <input type="checkbox"/> treatment plan reviewed and/or revised due to level of need and support <input type="checkbox"/> treatment plan reviewed and/or revised due to medical / health status, including medication review <input type="checkbox"/> treatment plan reviewed and/or revised due to unidentified risk or safety issues; safety plan reviewed / modified <input type="checkbox"/> other, describe: _____ |
| | <input type="checkbox"/> Resolution following member review. Describe specifically how revision(s) will prevent or diminish the probability of future occurrence(s). <input type="checkbox"/> Treatment plan reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____ |

The Member Review section identifies incident-specific resolutions focused on the actions, inactions, abilities, needs or goals of the member. Please select all that apply. Fields in the **Member Review** section of the Incident-specific Resolutions include:

- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO BEHAVIORAL ISSUES:**
 - ☒ The member experienced difficulty with following the treatment regimens on a consistent basis. The treatment plan was reviewed, and revised if appropriate to provide the member with necessary prompts and other supports to assure optimal care.
 - ☒ Proper behavioral assessment, including risk to self or others, was reevaluated and modified as necessary.
- **TREATMENT PLAN REVIEWED AND / OR REVISED TO REFLECT MEMBER'S GOALS:**
 - ☒ A timely and complete member planning process is present. The planning process includes essential components.
 - ☒ The planning process includes the involvement of sufficient knowledgeable people.
- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO COGNITIVE ABILITIES:**
 - ☒ The treatment plan was reviewed, and revised if appropriate so that the member is aware of what tasks they need to do and when those tasks are to be performed.
 - ☒ The treatment plan was reviewed, and revised if appropriate due to the member's cognitive skills to assure understanding and the successful completion of critical care activities.

- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO COMMUNICATION NEEDS:**
 - ☒ The member is able to communicate needs and concerns that required staff assistance or intervention.
 - ☒ Alternative and assistive communication systems are in place to assure the member can communicate.
- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO PHYSICAL ABILITIES:**
 - ☒ The member has the physical ability to prevent the incident without staff or other support.
 - ☒ A physical assessment was reevaluated and modified as necessary.
- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO LEVEL OF NEED OR SUPPORT:**
 - ☒ The treatment plan was reviewed, and revised if appropriate to reflect the member's level of need for support.
 - ☒ The presence of supervision or observation during the activity or event was recognized and provided as necessary.
- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO MEDICAL / HEALTH STATUS, INCLUDING MEDICATION REVIEW:**
 - ☒ The medical and health status of the member was complex and required close monitoring so is was reassessed and modified as necessary.
 - ☒ A timely and complete medical and health assessment was conducted.
 - ☒ Necessary supplemental tests were performed.
- **TREATMENT PLAN REVIEWED AND / OR REVISED DUE TO UNIDENTIFIED RISK OR SAFETY ISSUES; SAFETY PLAN MODIFIED:**
 - ☒ The member was placed in a novel or unique situation and the treatment plan was reassessed and modified as necessary.
 - ☒ He or she is now familiar with the demands and risks of the situation or the necessary supports are in place.
 - ☒ Proper behavioral assessment, including risk to self or others, was reevaluated and modified as necessary.
 - ☒ The assessment or planning process was conducted in a timely fashion.
- **OTHER:** - Select and describe the specific member review in the narrative box.
- **RESOLUTION FOLLOWING MEMBER REVIEW:** - Select this checkbox if any previous fields in this section were marked. Describe specifically how the revisions selected will prevent or diminish the probability of future occurrences.
- **TREATMENT PLAN REVIEWED AND NO CHANGES REQUIRED:** - If no previous fields were selected then select this checkbox. Describe in the narrative box how this adverse incident was isolated with a minimal probability of reoccurrence.

EQUIPMENT & SUPPLIES REVIEW

Figure 34: Equipment & Supplies Review, Part 3 Resolution Review

| | | |
|---|--|---|
| Equip & Supplies Review <input type="checkbox"/> | (Please note: Complete the Equipment & Supplies Review section only if their presence, absence and/or condition contributed to the incident.) | |
| | Review of equipment and / or supplies: (select all that apply) | |
| | <input type="checkbox"/> necessary equipment needs to be repaired | <input type="checkbox"/> necessary equipment needs to be replaced |
| | <input type="checkbox"/> necessary equipment needs to be purchased | <input type="checkbox"/> other, describe _____ |
| <input type="checkbox"/> Resolution following equipment and supplies review. Describe specifically how this review(s) will prevent or diminish the probability of future occurrence(s). _____ | | |
| <input type="checkbox"/> Equipment and supplies reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____ | | |

The Equipment and Supplies Review section identifies incident-specific resolutions focused on the availability of adequate equipment or supplies. Please select all that apply. Fields in the **Equipment and Supplies Review** section of the Incident-specific Resolutions include:

- **NECESSARY EQUIPMENT NEEDS TO BE REPAIRED:**

- ☒ Necessary equipment required maintenance and the repair or maintenance has been provided.
- ☒ Equipment was broken or did not operate properly due to lack of maintenance and the condition has been resolved.
- **NECESSARY EQUIPMENT NEEDS TO BE REPLACED:**
 - ☒ Equipment was not properly designed or had defects in its manufacturing and has been replaced.
 - ☒ The equipment was not assembled properly and this has been corrected.
 - ☒ Equipment was not used as intended and instruction has been provided.
- **NECESSARY EQUIPMENT NEEDS TO BE PURCHASED:** - Adapted or other necessary equipment was not available or was inadequate to the needs of the member and the situation has been corrected.
- **OTHER:** - Select and describe the specific equipment and supplies review in the narrative box.
- **RESOLUTION FOLLOWING MEMBER REVIEW:** - Select this checkbox if any previous fields in this section were marked. Describe specifically how the actions selected will prevent or diminish the probability of future occurrences.
- **EQUIPMENT AND SUPPLIES REVIEWED AND NO CHANGES REQUIRED:** - If no previous fields were selected then select this checkbox. Describe in the narrative box how this adverse incident was isolated with a minimal probability of reoccurrence.

ENVIRONMENTAL REVIEW

Figure 35: Environment Review, Part 3 Resolution Review

| | | |
|---------------------------|--|--|
| Environ Review | (Please note: Complete the Environment Review section only if the identified condition or circumstance contributed to the incident.) | |
| | Review of environment: (select all that apply) | |
| | <input type="checkbox"/> member's physical environment evaluated, and modified if necessary, for safety issues <input type="checkbox"/> member's physical environment evaluated, and modified if necessary, to increase accessibility <input type="checkbox"/> member's interpersonal relationships within their environment evaluated, and accommodated / modified if necessary, for safety reasons <input type="checkbox"/> other, describe _____ | |
| | <input type="checkbox"/> Resolution following environmental review. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____ | |
| | <input type="checkbox"/> Environment reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____ | |

The Environmental Review section identifies incident-specific resolutions focused on environmental circumstances. Please select all that apply. Fields in the **Environmental Review** section of the Incident-specific Resolutions include:

- **MEMBER'S PHYSICAL ENVIRONMENT EVALUATED, AND MODIFIED IF NECESSARY, FOR SAFETY ISSUES:**
 - ☒ The physical environment has been evaluated regarding required building or safety codes or standards.
 - ☒ The physical environment has been assessed for the intended use to which it was put.
 - ☒ The environment was evaluated for noise and distractions that could compromise the ability of staff to attend properly to tasks.
 - ☒ The member was placed in a novel or unique situation. He or she is now familiar with the demands and risks of the situation.
 - ☒ Adequate emergency procedures were reevaluated and available to staff.
 - ☒ An emergency plan was evaluated and modified, as necessary.
- **MEMBER'S PHYSICAL ENVIRONMENT EVALUATED, AND MODIFIED IF NECESSARY, TO INCREASE ACCESSIBILITY:**
 - ☒ The physical environment meets established or required building or safety codes or standards.
 - ☒ The environment is handicapped accessible and contains needed adaptations.
 - ☒ The environment was neat and uncluttered and did not impeded safe ambulation or movement.

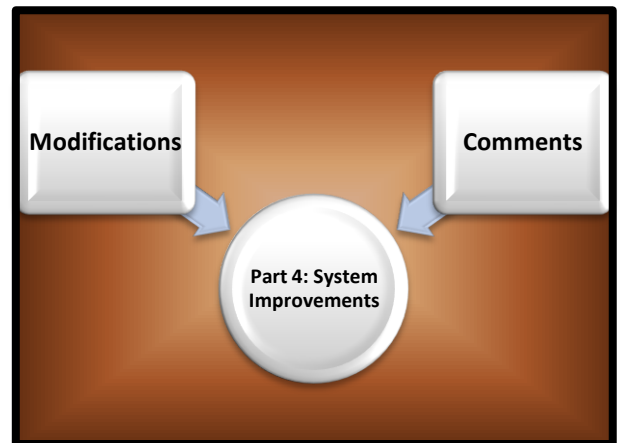
- **MEMBER'S INTERPERSONAL RELATIONSHIPS WITHIN THEIR ENVIRONMENT EVALUATED, AND ACCOMMODATED / MODIFIED, IF NECESSARY, FOR SAFETY REASONS:**
☒ The member's safety and welfare are assured within their family or social network.
- **OTHER:** - Select and describe the specific environmental review in the narrative box.
- **RESOLUTION FOLLOWING MEMBER REVIEW:** - Select this checkbox if any previous fields in this section were marked. Describe specifically how the actions selected will prevent or diminish the probability of future occurrences.
- **NO RESOLUTION REQUIRED:** - If no previous fields were selected then select this checkbox. Describe in the narrative box how this adverse incident was isolated with a minimal probability of reoccurrence.

PART 4 – SYSTEM MODIFICATIONS

Part 4 is optional. Up to this point, the provider has completed discovery activities and resolved incident-specific situations. By analyzing trend data on incidents the provider may implement system changes as a proactive measure. If this occurs, this part of the incident reporting system will capture information on system resolutions.

The second section of Part 4 is an opportunity for the provider to add additional comments. Please select all that apply.

Figure 36: System Resolutions, Part 4 System Modifications



| Systemic Resolutions | |
|----------------------|--|
| Systemic Resolution | <p><small>(Please note: Completion of the Systemic Resolutions section is optional. If you chose to complete this section, please provide a brief summary with a detailed description of the changes and/or modifications made.)</small></p> <p><input type="checkbox"/> Policy - Reviewed formal written policy or procedure governing the activity, and modified as needed. Staff are able to reference agency guidelines or protocols.</p> <p><input type="checkbox"/> Consistent implementation of policy - Reviewed, and modified as necessary, to assure that verbal instructions are the same as procedural requirements. Policies and procedures are up to date.</p> <p><input type="checkbox"/> Adequate policy - Policies and procedures are complete, meet regulatory requirements, and are consistent with established standards and accepted practice expectations. Policies and procedures are clear and concise.</p> <p><input type="checkbox"/> Communication and awareness - There is adequate communication re: new policy requirements. Staff and others are aware of changes or revisions to policy or procedure.</p> <p><input type="checkbox"/> Employee screening - There were adequate policy requirements for screening employees. Individuals with established histories of behavior that could compromise member safety/care – including abuse and neglect – are not working with members.</p> <p><input type="checkbox"/> Training - There are adequate policy requirements for training. Staff are required by policy to meet any minimum training requirements or demonstrate competencies.</p> <p><input type="checkbox"/> Fiscal control - There are adequate and consistent policy requirements for the management and control of member funds.</p> <p><input type="checkbox"/> Assessment - There are adequate policy requirements for proper assessment of member health, behavioral, and other critical support needs and preferences.</p> <p><input type="checkbox"/> Planning - There are adequate policy requirements for proper member planning and revision of supports based on changing needs.</p> <p><input type="checkbox"/> Monitoring - There are adequate policy requirements for monitoring services and supports to assure safety, meeting critical needs, and providing services in accordance with member plans and agency requirements.</p> <p><input type="checkbox"/> Documentation - There are adequate policy requirements for member records – including privacy – and documentation.</p> <p><input type="checkbox"/> Other, describe</p> <p><input type="checkbox"/> Resolution of systemic factor(s). Describe specifically how these reviews and/or assurances will prevent or diminish the probability of future occurrence(s).</p> <p><input type="checkbox"/> No resolution required. Describe how this adverse incident was isolated with a minimal probability of a recurrence.</p> <p>Detailed description:</p> |

Fields under **Systemic Resolution** include:

POLICY: - Reviewed formal written policy or procedure governing the activity, and modify as needed. Staff are able to reference agency guidelines or protocols.

CONSISTENT IMPLEMENTATION OF POLICY: – Reviewed, and modified as necessary, to assure that verbal instructions are the same as procedural requirements. Policies and procedures are up to date.

ADEQUATE POLICY: - Policies and procedures are complete, meet regulatory requirements, and are consistent with established standards and accepted practice expectations. Policies and procedures are clear and concise.

COMMUNICATION AND AWARENESS: - There is adequate communication re: new policy requirements. Staff and others are aware of changes or revisions to policy or procedure.

EMPLOYEE SCREENING: - There were adequate policy requirements for screening employees. Individuals with established histories of behavior that could compromise member safety/care – including abuse and neglect – are not working with members.

TRAINING: - There are adequate policy requirements for training. Staff are required by policy to meet any minimum training requirements or demonstrate competencies.

FISCAL CONTROL: - There are adequate and consistent policy requirements for the management and control of member funds.

ASSESSMENT: - There are adequate policy requirements for proper assessment of member health, behavioral, and other critical support needs and preferences.

PLANNING: - There are adequate policy requirements for proper member planning and revision of supports based on changing needs.

MONITORING: - There are adequate policy requirements for monitoring services and supports to assure safety, meeting critical needs, and providing services in accordance with member plans and agency requirements.

DOCUMENTATION: - There are adequate policy requirements for member records – including privacy – and documentation.

OTHER: - Select and describe the specific system resolution in the narrative box.

RESOLUTION OF SYSTEM FACTORS: - Select this checkbox if any previous fields in this section were marked. Describe specifically how these reviews and / or assurances will prevent or diminish the probability of future occurrences.

NO RESOLUTION REQUIRED: - If no previous fields were selected then select this checkbox. Describe in the narrative box how this adverse incident was isolated with a minimal probability of reoccurrence.